STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF INDIANAPOLIS	7365 E 16TH ST INDIANAPOLIS, IN 46219

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R000000	This visit was for a State Residential Licensure Survey. This visit included Investigation of Complaint # IN00136103. Complaint # IN00136103- Substantiated. no deficiencies related to the allegations are cited. Date of Survey: October 8, 9, 10, 2013 Facility number: 005729 Provider number: 005729 AIM number: N/A Survey Team: Courtney Mujic, RN-TC Beth Walsh, RN Tom Stauss, RN Census bed type: Residential: 68 Total: 68 Census payor type: Medicaid: 62 Other: 6 Total: 68 Sample: 7 These State findings are cited in	R000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	accordance with 410 IAC 16.2-5. Quality review completed on October 17, 2013, by Janelyn Kulik, RN.			

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R000192	410 IAC 16.2-5-1.6(p) Physical Plant Standards - Nonconformance (p) The facility shall have a janitor's closet conveniently located on each resident occupied floor of the facility. The janitor's closet shall contain a sink or floor receptacle and storage for cleaning supplies. The door to the janitor's closet shall be equipped with a lock and shall be locked when hazardous materials are stored in the closet. Based on observation, interview, and record review, the facility failed to ensure a janitor's closet which stored potentially hazardous chemicals was closed and locked. This had the potential to affect all 68 residents who resided in the facility. Findings include: An observation, on 10/9/2013 at 1:04 p.m., indicated the second floor janitor's closet, located next to the east wing second floor elevator, was open. Inside the closet on the floor was a container. The container, which was partially full, was labeled [name of company] Enzymatic Odor Counteractant. An observation on 10/10/2013 at 10:01 a.m. of the second floor janitor's closet indicated the door was open. Inside the closet on the floor was a container. The container, which	R000192	1.)The deficient practice as identified as an unlocked janitors closet on the East wing of the second floor has been corrected. No residents were found to be affected by this unlocked door.2.) All residents in the facility had the potential to have been affected by this deficient practice. 3) The following corrections were made to the door and its closing mechanism: The closing mechanism was adjusted to ensure that the door will automatically pull shut and a new locking mechanism was installed to ensure that the door will be locked with each closure.4. All staff was in-serviced on 10/25/13 at a mandatory meeting on the importance of closing and locking all work areas upon exit. 5. The Director of Maintenance will monitor the door on all of his normal working days to ensure that it is functioning properly.	10/29/2013

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	was partially full, was labeled [name of company] Enzymatic Odor Counteractant. An interview with the Maintenance Director, on 10/10/2013 at 2:34 p.m., indicated the closet was "his closet" and that the closet was "supposed to always be closed and locked." Record review of a Material Safety Data Sheet, provided by the Administrator on 10/10/2013 at 1:00 pm, indicated, the "following hazards exist from inhalation or ingestion of the [name of company] "Enzymatic Odor Counteractant" chemical formula: Gastrointestinal irritation, nausea, vomiting, diarrhea, nasal and respiratory irritation, dizziness, nausea, headache, and possible unconsciousness or asphyxiation."			

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R000241	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, interview, and record review, the facility failed to administer medication as ordered by the Physician for 1 of 5 residents reviewed for medication administration (Resident #49) Findings include: During a medication administration observation of Resident #49, on 10/9/2013 at 11:35 a.m., LPN #1 administered hydrocodone/acetaminophen 7.5/325 milligram (pain medication) to the Resident. LPN #1 marked in the MAR (Medication Administration Record), the medication was given. During a review of the October MAR, there were initials in the medication slot, for hydrocodone/acetaminophen 7.5/325 mg, for the date of 10/9/13 and the slot for 2 p.m. In front of the 2, there was a handwritten 1. There were initials in the date slots for 10/1/2013-10/8/2013 on the same	R000241	1.)The deficient practice identified for resident #49 cannot be corrected in arrears, a new order has been received from the physician to update the medication administration times for the medication in question for Resident #49. . No other residents were found to have been affected.2.) All residents in the facility had the potential to have been affected by this deficient practice.3.) In an ongoing effort to ensure compliance and quality assurance an in-service was conducted on 10/25/13 with all LPN's and QMA's, where a detailed review of the policy on Medication Administration was conducted by the HFA and Director of Healthcare Services (DHS).4.) Training will be ongoing with clinical staff on a monthly basis to ensure that the Medication Administration Policy is being followed and to ensure that all medications are then being given as directed by the physician's orders.5. In an effort to monitor that the Medication Administration Policy is being	10/29/2013

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	line with the 2 and handwritten 1, indicating the medication was given on those dates and time. Review of the October Physician's Orders, indicated there was an order for hydrocodone/acetaminophen 7.5/325 mg (milligram), 1 tablet by mouth 3 times daily at 8 a.m., 2 p.m., 8 p.m. The order was initiated on 3/27/2013. Review of a document titled, "Medication Times Are As Followed," received from the Administrator, on 10/8/2013 at 1:15 p.m., indicated "Noon" medications were given at 11 a.m.-1 p.m. and "Afternoon" medications were given at 1 p.m.-3 p.m. During an interview with the Director of Health Services (DHS), on 10/9/2013 at 1:27 p.m., she indicated staff were expected to follow physician's orders and was unsure why Resident #49, was given the medication at 11:35 a.m., when the October Physician's Orders indicated the medication was to be given at 8 a.m., 2 p.m., and 8 p.m. She also indicated she did notice how the MAR had a handwritten 1 in front of the 2 for hydrocodone/acetaminophen 7.5/325 mg administration slot. The		followed and that this deficient practice does not occur again, the DHS or her designee will conduct a visual inspection of all medication administration records on a monthly basis as evidenced by the updated rewrites. 6.) The DHS or her designee will conduct a visual inspection of all medication orders for all new admitting residents and for all residents returning from a hospital or SNF stay within one week of return to the facility to ensure that all orders have been received and that all medications are being administrated as directed by physician's orders. This will be evidence by a notation in the residents nursing notes.	

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	DHS indicated she would look to see if there was another order in the chart, for the medication to be given at 12 p.m., instead of 2 p.m. On 10/10/2013, at 9:49 a.m., the DHS indicated she was unable to locate an order for the above medication to be given at 12 p.m., instead of 2 p.m., as ordered, but she was going to keep looking. The DHS also indicated she was going to call the MD (medical doctor) office to clarify the order. At 11:01 a.m., on 10/10/2013, the DHS indicated she was unable to locate another order related to the timing of the above medication, but felt there was probably a mistake related to the administration time of the medication. During an interview, with LPN #2, on 10/10/2013 at 11:36 a.m., she indicated when looking at the October MAR for Resident #49, hydrocodone/acetaminophen 7.5/325 mg was probably administered at 12 p.m., instead of 2 p.m., for the dates 10/1/2013-10/8/2013, since there was a handwritten "1" in front of the 2 and there were initials in the date/time slot. She also indicated there was a miscommunication regarding the order for the medication and the			

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	timing of the administration of the medication. On 10/10/2013 at 12:31 p.m., the DHS indicated she called the MD office to say there was a discrepancy regarding the timing of the administration of hydrocodone/acetaminophen 7.5/325 mg and how the October Physician's Order was written. She also indicated she was having a new order written for the medication. Review of a policy titled, "Medication Administration," received by the DHS, on 10/10/2013 at 1:35 p.m., indicated, "Residents of the facility shall receive medications as ordered by their physician to treat specific medical conditions." A copy of a fax sent to the MD office, was received by the DHS, on 10/10/2013 at 2:27 p.m. It indicated the following message, "(Name of Resident #49) take [sic] hydrocodone apap 7.5/325 mg P.O. (by mouth) (symbol for at) 8a 2p 8p [sic] may we (symbol for change) times to 8a 12p 8p [sic] This is how he has been taking it (Name of DHS)." The fax indicated it was sent to the MD office at 12:50 p.m., on 10/10/2013, and was received back by the facility with			

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	a "yes" circled at 2:24 p.m., on 10/1020/13.			